



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

VISTA MEDICAL CENTER HOSPITAL  
4301 VISTA ROAD  
PASADENA TX 77504-2117

DWC Claim #: 04359640  
Injured Employee: RUBY FRANCOIS  
Date of Injury: 09/26/03  
Employer Name: EMERALD FOODS INC  
Insurance Carrier #: WC973-426088 HOD

#### **Respondent Name**

LIBERTY INSURANCE CORP

#### **Carrier's Austin Representative Box**

Box Number 01

#### **MFDR Tracking Number**

M4-05-B488-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Vista Medical Center Hospital charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum of 70% of billed charges. This is supported by a managed care contract with 'Focus'."

**Amount in Dispute:** \$13,087.40

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The entire bill was denied x206, not related to the compensable injury. Attached you will find a copy of the TWCC21 filed disputing all income and medical benefits related to the back and left leg. The carrier has accepted the injury to the left foot, which resulted from a compensable work-related injury. The injuries to her back and left leg did not arise out of the course and scope of employment.."

**Response Submitted by:** Liberty Mutual Insurance, 2875 Browns Bridge Road, Gainesville, GA 30504

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 1, 2005	Outpatient Surgery	\$13,087.40	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**